RULE-MAKING ORDER

CR-103 (June 2004)
(Implements RCW 34.05.360)

Agency: Office of Insurance Commissioner

☒ **Permanent Rule**
☐ **Emergency Rule**

Effective date of rule:
Permanent Rules
☐ 31 days after filing.
☒ Other (specify) July 22, 2007 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Effective date of rule:
Emergency Rules
☐ Immediately upon filing.
☐ Later (specify) _____

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?
☐ Yes ☒ No If Yes, explain:

Purpose: These are new procedural rules that implement chapter 48.140 RCW (amended by Chapter 32, 2007 Laws) and RCW 7.70.140. These rules describe the process and procedures that reporting entities and claimants must use to report medical malpractice closed claim and/or settlement data to the commissioner.

Insurance Commissioner Matter No. R 2006-02

Citation of existing rules affected by this order:
Repealed:
Amended:
Suspended:

Statutory authority for adoption: RCW 48.02.060; RCW 48.140.060; RCW 7.70.140

Other authority :

PERMANENT RULE ONLY (Including Expedited Rule Making)
Adopted under notice filed as WSR 07-07-126 on March 21, 2007.
Describe any changes other than editing from proposed to adopted version:

1. WAC 284-24D-160 was revised to be consistent with Chapter 32, 2007 Laws that amends RCW 48.140.020 and becomes effective July 22, 2007.
2. WAC 284-24E-060 was split into two sections (WAC 284-24E-060 and WAC 284-24E-063) because the content of the section was inconsistent with the heading. Information related to the types of claims that must be reported was left in WAC 284-24E-060, and information related to when a claim is considered settled was moved to WAC 284-24E-063. These sections are now consistent with WAC 284-24D-060 and WAC 284-24D-080.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: phone ( ) _____
Address: fax ( ) _____
e-mail _____

EMERGENCY RULE ONLY
Under RCW 34.05.350 the agency for good cause finds:
☐ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
☐ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

Date adopted:
June 4, 2007

NAME (TYPE OR PRINT)
Mike Kreidler

SIGNATURE
Mike Kreidler

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: June 04, 2007
TIME: 8:11 AM

WSR 07-12-057

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	4	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	56	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New _____ Amended _____ Repealed _____

The number of sections adopted in the agency's own initiative:

New _____ Amended _____ Repealed _____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New _____ Amended _____ Repealed _____

The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	56	Amended	_____	Repealed	_____

Chapter 284-24D WAC

MEDICAL MALPRACTICE CLOSED CLAIM DATA REPORTING RULES FOR FACILITIES AND PROVIDERS

NEW SECTION

WAC 284-24D-010 Purpose. This chapter contains procedural rules to implement chapter 48.140 RCW. This chapter describes the rules, practices and procedures that insuring entities, self-insurers, health care facilities and providers must use to report data to the commissioner as required by chapter 48.140 RCW.

NEW SECTION

WAC 284-24D-020 Definitions. The definitions in this section apply throughout this chapter.

(1) "Allocated loss adjustment expense" or "ALAE" means defense and cost containment expenses paid or incurred for defense, litigation and medical cost containment expenses and services. Either internal staff, such as in-house counsel or professional medical staff, or external staff, such as defense counsel or expert witnesses, may provide defense and cost containment services.

(a) Defense and cost containment expenses and services include:

(i) Defense services provided by:

(A) Attorneys or expert witnesses; and

(B) Private investigators, hearing representatives or fraud investigators.

(ii) Cost containment activities and services performed by external or internal experts to defend the claim, including:

(A) Case evaluation, such as evaluating whether the medical care provided met professional standards;

(B) Risk assessment;

(C) Case preparation and management;

(D) Medical record review; and

(E) Settlement negotiations.

(iii) Specific case-related expenses, such as:

(A) Surveillance expenses;

(B) Court costs;
(C) Medical examination fees;
(D) The costs of laboratory, X-ray and other medical tests;
(E) Autopsy expenses;
(F) Stenographic expenses;
(G) Fees associated with witnesses and summonses; and
(H) The costs to obtain copies of documents.
(b) Allocated loss adjustment expenses do not include:
(i) Expenses incurred to determine whether coverage is available; or
(ii) Expenses or costs associated with external or internal claims adjusting staff.
(2) "Claim" means the same as in RCW 48.140.010(1).
(3) "Claim identifier" means the unique number assigned to a claim by the reporting entity as required by RCW 48.140.030 (1)(a).
(4) "Claimant" means the same as in RCW 48.140.010(2).
(5) "Closed claim" means the same as in RCW 48.140.010(3).
(6) "Commissioner" means the insurance commissioner.
(7) "Companion claims" means the same as in RCW 48.140.030 (1)(b).
(8) "Economic damages" means the same as in RCW 4.56.250 (1)(a).
(9) "Excess insuring entity" means an insuring entity that provides insurance coverage above the limits of primary insurance or a self-insured retention.
(10) "Facility" means the same as in RCW 48.140.010(6).
(11) "Paid and estimated economic damages" means economic damages paid to a claimant based on:
(a) Objectively verifiable evidence; and
(b) Estimates developed from the injured person's available personal data and related economic data. Estimated economic damages typically include, but are not limited to:
(i) Lost earnings and benefits;
(ii) Lost earnings potential;
(iii) Lost value of household services; and
(iv) Future medical care costs.
(12) "Incident identifier" means the unique number assigned by the reporting entity to a series of closed claims that result from a single incident or related series of incidents of actual or alleged medical malpractice.
(13) "Insuring entity" means the same as in RCW 48.140.010(8).
(14) "Medical malpractice" means the same as in RCW 48.140.010(9).
(15) "OIC" means office of insurance commissioner.
(16) "Primary insuring entity" means the insuring entity that originates the primary layer of insurance coverage.
(17) "Provider" means the same as in RCW 48.140.010(7).
(18) "Record identifier" means a number assigned to a claim by the reporting site when a reporting entity first enters closed claim data.
(19) "Reporting entity" means any person or entity required to report data under RCW 48.140.020.

(20) "Reporting site" means the OIC web-based application that insuring entities, facilities, providers, and self-insurers must use to report medical malpractice closed claim data.

(21) "Self-insurer" means the same as in RCW 48.140.010(11).

(22) "User ID" is a permanent number assigned by the reporting site to each insuring entity, self-insurer, facility or provider.

NEW SECTION

WAC 284-24D-030 How will the commissioner ensure data confidentiality under RCW 48.140.060(2)? RCW 42.56.400(11) protects data filed under chapter 48.140 RCW from public disclosure. To ensure data confidentiality, the commissioner will:

(1) Develop a secure web-based data reporting application;

(2) Train OIC staff on applicable laws and agency practices related to protecting confidential and privileged information;

(3) Limit access to the claim data base to OIC staff responsible for preparing the statistical summaries and annual report;

(4) Develop and implement confidentiality procedures to be used by staff that has access to the closed claim data base;

(5) Develop procedures to use if data are accidentally released; and

(6) Use aggregate data in summaries and reports so that individual claim data cannot be identified.

NEW SECTION

WAC 284-24D-040 How are closed claims reported to the commissioner? (1) Except as provided in subsection (2) of this section, reporting entities must use the reporting site maintained by the OIC to report closed claims. To help reporting entities collect data, the commissioner will post reporting forms on the OIC internet site so that reporting entities can organize data before entering data into the reporting site.

(2) The commissioner may permit a reporting entity to transmit data electronically in an alternative format if the reporting entity develops, at its own expense, an interface that is compatible with the OIC closed claim data base.

NEW SECTION

WAC 284-24D-050 How will the OIC assign user ID codes to reporting entities? The reporting site will assign a permanent user ID to each reporting entity the first time it enters a closed claim into the reporting site.

NEW SECTION

WAC 284-24D-060 What types of claims must be reported to the commissioner? The types of closed medical malpractice claims that must be reported to the OIC include:

(1) Claims closed with an indemnity payment;

(2) Claims closed with paid allocated loss adjustment expenses; and

(3) Claims closed with both indemnity payments and allocated loss adjustment expenses.

NEW SECTION

WAC 284-24D-070 Are write-offs or other small sums of money provided as customer service gestures considered claims? If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under RCW 48.140.010(1). Reporting entities are not required to report these types of accommodations to the commissioner.

NEW SECTION

WAC 284-24D-080 When is a claim considered closed? A claim is closed on the date the reporting entity takes final administrative action to close the claim. Final administrative action occurs after the reporting entity:

(1) Issues the final payment to the claimant in the form of a check or draft;

(2) Pays all outstanding bills for allocated loss adjustment expenses; and

(3) If applicable, receives all indemnity and allocated loss adjustment expense claim payment data needed for reporting under

this chapter from a facility, provider or excess insuring entity.

NEW SECTION

WAC 284-24D-090 When are closed claim reports due? Under RCW 48.140.020, reporting entities must report all claims closed in the preceding calendar year to the commissioner.

(1) Beginning in 2009, closed claim reports for the prior calendar year are due by March 1.

(2) A reporting entity may report a closed claim any time after the claim is closed, but no later than March 1.

NEW SECTION

WAC 284-24D-100 Can a reporting entity reopen a claim or make changes to previously reported data? The reporting site will allow the reporting entity to change previously reported closed claim data, subject to these rules:

(1) OIC will freeze data contained in the reporting site from March 15 through June 30 each year so the OIC can prepare reports and statistical summaries as required by RCW 48.140.040 and 48.140.050. The commissioner may accept changes to previously reported data if a correction or omission will significantly affect the conclusions stated in the annual report.

(2) After June 30, the reporting site will allow a reporting entity to change previously reported data.

(a) The reporting entity can reopen a claim report using their permanent user ID and the record identifier and make changes or corrections to data.

(b) Changes and corrections submitted by reporting entities after June 30 of each year will appear in future reports and statistical summaries.

NEW SECTION

WAC 284-24D-110 How should reporting entities assign claim and incident identifiers? (1) Consistent with requirements of RCW 48.140.030(1), the reporting entity must assign a different claim identification number to each closed claim report.

(a) The claim identifier must consist solely of numbers. When

the reporting entity enters a claim into the reporting site, the site will automatically combine the reporting entity's user ID with the claim identifier to create a unique record identifier for each claim.

(b) The OIC will use the record identifier to trace the claim for auditing purposes.

(2) If a claimant makes claims against more than one facility or provider, the insuring entity or self-insurer must report each claim separately and include an incident identifier.

(a) The incident identifier for companion claims must consist solely of numbers.

(b) The insuring entity or self-insurer is responsible to report claims only if it provides insurance coverage for a facility or provider and defends the claim.

NEW SECTION

WAC 284-24D-120 When is the primary insuring entity responsible for reporting closed claims to the commissioner? Primary insuring entities are principally responsible for reporting closed claim data required under chapter 48.140 RCW and this chapter to the commissioner.

(1) The primary insuring entity must report the total amounts paid to settle the claim, including any claim payments or ALAE payments made by:

(a) A facility or provider;

(b) An excess insuring entity; or

(c) Any other person or entity on behalf of the provider.

(2) Facilities or providers insured by the primary insuring entity must cooperate and assist the primary insuring entity in the reporting process.

(3) If a primary insuring entity and one or more excess insuring entities combine to pay a claim:

(a) The primary insuring entity must report all paid indemnity and allocated loss adjustment expense; and

(b) The excess insuring entity must cooperate and assist the primary insuring entity in the reporting process.

NEW SECTION

WAC 284-24D-130 When is an excess insuring entity responsible for reporting closed claims to the commissioner? (1) If an excess insuring entity insures a self-insurer and makes indemnity payments or incurs allocated loss adjustment expenses, the excess insuring

entity is principally responsible to report closed claim data required under chapter 48.140 RCW and this chapter.

(a) Self-insurers must report all claim payments and allocated loss adjustment expenses to the excess insuring entity for reporting purposes; and

(b) The excess insuring entity must report data on behalf of itself and the self-insurer.

(2) An excess insurer is not responsible to report closed claim data reported by a primary insuring entity under WAC 284-24D-120.

NEW SECTION

WAC 284-24D-140 When is a self-insurer responsible for reporting closed claims to the commissioner? If a closed claim payment falls within its self-insured retention, the self-insurer must report closed claim data required under chapter 48.140 RCW and this chapter to the commissioner.

NEW SECTION

WAC 284-24D-150 May a self-insurer report claims on behalf of itself and an excess insuring entity? A self-insurer may designate itself to be the principal reporting entity and report closed claim data on behalf of itself and any excess insurer. If the self-insurer designates itself to be the principal reporting entity, the self-insurer must:

(1) Notify the commissioner in writing of this arrangement;

(2) Report closed claim data required under chapter 48.140 RCW and this chapter on behalf of itself and the excess insuring entity; and

(3) Accept responsibility for compliance with RCW 48.140.020(2).

NEW SECTION

WAC 284-24D-160 When is a facility or provider principally responsible for reporting closed medical malpractice claims to the commissioner? Under RCW 48.140.020(1), a facility or provider must report closed claims if the facility or provider:

(1)(a) Makes indemnity payments directly to the claimant or incurs ALAE expenses to defend the claim, or both; and

(b) There is no insurance coverage available from an insuring entity or self-insurer to defend or pay for the claim; or

(2) Is insured by a risk retention group and the risk retention group refuses to report closed claim data and asserts that the federal Liability Risk Retention Act (95 Stat. 949; 15 U.S.C. 3901 et seq.) preempts state law; or

(3) Is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claim data and asserts a federal exemption or other jurisdictional preemption.

NEW SECTION

WAC 284-24D-170 What does "date of notice" mean? RCW 48.140.030 (8)(b) says that reporting entities must report the date that the insuring entity, self-insurer, facility or provider is presented with the claim. For reporting purposes, the "date of notice" is the date on which the:

(1) Insured notifies the primary insuring entity or self-insurer of a claim if insurance coverage is available; or

(2) Claimant notifies the facility or provider of a claim if insurance coverage is not available.

NEW SECTION

WAC 284-24D-180 How should the type of medical specialty be reported? When reporting medical specialties as required under RCW 48.140.030(2), reporting entities must use the *Specialty Codes* published by the National Practitioner Data Bank (NPDB).

NEW SECTION

WAC 284-24D-190 How should the type of health care facility be reported? When reporting the type of health care facility under RCW 48.140.030(3), the reporting entity must use the *Type of Organization Codes* published by the NPDB. Public facilities, such as prisons and universities, must review the NPDB *Type of Organization Codes* and enter the most similar classification.

NEW SECTION

WAC 284-24D-200 What should be reported as the primary location where the medical malpractice incident occurred? When reporting the location within a facility where the incident occurred under RCW 48.140.030(4), the reporting entity must use the incident locations published by the Physician Insurers Association of America in conjunction with its data-sharing project. The reporting entity must report one of these locations:

(1) Catheterization lab;
(2) Critical care unit;
(3) Dispensary;
(4) Emergency department;
(5) Labor and delivery room;
(6) Laboratory;
(7) Nursery;
(8) Operating room;
(9) Outpatient department;
(10) Patient room;
(11) Pharmacy;
(12) Physical therapy department;
(13) Radiation therapy department;
(14) Radiology department;
(15) Recovery room;
(16) Rehabilitation center;
(17) Special procedure room;
(18) Location other than an inpatient facility:
(a) Clinical support center, such a laboratory or radiology center;
(b) Office;
(c) Walk-in clinic; or
(d) Other;
(19) Other department in hospital;
(20) Unknown; and
(21) Other.

NEW SECTION

WAC 284-24D-210 How should the incident city be reported? When reporting the incident city under RCW 48.140.030(5), the reporting entity must report the incident city based on the location of the facility where the incident occurred. If more than one incident led to the claim, the reporting entity must choose the location where the incident occurred that most directly caused the injury.

NEW SECTION

WAC 284-24D-220 How should injury severity be reported using the National Practitioner Data Bank (NPDB) severity scale? When reporting the severity of an injury under RCW 48.140.030(7), the reporting entity must report using the NPDB severity scale. This scale shows the medical outcome for temporary and permanent injuries, and is included below.

(1) Temporary injuries include:

(a) Emotional injury only, such as fright, where no physical damage occurred;

(b) Insignificant injury such as lacerations, contusions, minor scars or rash where no delay in recovery occurs;

(c) Minor injury such as infection, fracture set improperly, or a fall in the hospital, where recovery is complete but delayed; or

(d) Major injury such as burns, surgical material left, drug side effect, brain damage, where recovery is complete but delayed.

(2) Permanent injuries include:

(a) Minor injury such as loss of fingers, loss or damage to organs, where the injury is not disabling;

(b) Significant injury such as deafness, loss of limb, loss of eye, loss of one kidney or lung;

(c) Major injury such as paraplegia, blindness, loss of two limbs, brain damage;

(d) Grave injury such as quadriplegia, severe brain damage, life long care or fatal prognosis; or

(e) Death.

(3) The reporting entity should report the principal injury if several injuries are involved.

NEW SECTION

WAC 284-24D-230 What should be reported as the reason for the medical malpractice claim? When reporting the reason for a medical malpractice claim under RCW 48.140.030(11), the reporting entity must use the same *Allegation Group and Specific Allegation Codes* published by the National Practitioner Data Bank.

NEW SECTION

WAC 284-24D-240 How should claim disposition information be reported? When reporting the final method of claim disposition under RCW 48.140.030(9), reporting entities must describe the

method of claim disposition using one of the descriptions listed below:

(1) Claim abandoned by claimant.

(2) Claim settled by the parties.

(3) Claim is disposed of by a court when the court issues a:

(a) Directed verdict for plaintiff:

(b) Directed verdict for defendant;

(c) Judgment notwithstanding verdict for plaintiff (judgment for defendant);

(d) Judgment notwithstanding verdict for defendant (judgment for plaintiff);

(e) Involuntary dismissal;

(f) Judgment for plaintiff;

(g) Judgment for defendant;

(h) Judgment for plaintiff after appeal; or

(i) Judgment for defendant after appeal.

(4) Claim settled by alternative dispute resolution process, whether resolved by:

(a) Arbitration award for plaintiff;

(b) Arbitration for defense;

(c) Mediation;

(d) Private trial; or

(e) Other type of alternative dispute resolution process.

NEW SECTION

WAC 284-24D-250 How should information about the timing of the settlement be reported? When reporting the timing of the settlement under RCW 48.140.030(9), reporting entities must report whether the claim is settled:

(1) Before filing suit, requesting arbitration or mediation hearing;

(2) Before trial, arbitration or mediation;

(3) During trial, arbitration or mediation;

(4) After trial or hearing, but before judgment or award;

(5) After judgment or decision, but before appeal;

(6) During an appeal; or

(7) After an appeal.

NEW SECTION

WAC 284-24D-260 Are claim payments reported on a gross or net basis? Reporting entities must report claim payments on a gross basis and provide the total amount paid to the claimant to settle

the claim. The reporting entity must not deduct the value of offsets or recoverables, such as:

(1) Reimbursement for a deductible by the insured;

(2) Reimbursement for claim payments by a reinsurer; or

(3) Anticipated subrogation recoveries.

NEW SECTION

WAC 284-24D-270 What does an insuring entity report when the damages exceed policy limits? When damages exceed the policy limits, the insuring entity must report the total amount it paid on behalf of its insured. The reporting entity must report:

(1) The actual claim payment, which may be either:

(a) The policy limit; or

(b) The actual amount paid on behalf of the insured. The actual amount paid by the insuring entity may be either higher or lower than the policy limit, depending on the settlement agreement.

(2) Additional payments made to the claimant by an insured facility or provider; and

(3) Allocated loss adjustment expenses paid by both the insuring entity and the insured.

NEW SECTION

WAC 284-24D-280 Are subrogation recoveries subject to reporting? Subrogation between insuring entities or self-insurers may occur if there is a dispute over which entity should respond to a lawsuit. If an insuring entity or self-insurer receives a subrogation payment, it must report subrogation proceeds and any ALAE incurred to obtain those proceeds. If necessary, the insuring entity may reopen the claim under WAC 284-24D-100.

NEW SECTION

WAC 284-24D-290 How are structured settlements reported? (1) If a claim is paid with a structured settlement agreement, the reporting entity must report the lump-sum payment for the purchase of the annuity.

(2) If a claim is paid with a combination of a lump-sum payment to the claimant and a structured settlement, the reporting

entity must report the sum of both payments.

NEW SECTION

WAC 284-24D-300 If the court itemizes damages, what information must be reported? If the court itemizes damages, the reporting entity must report these itemized damages:

(1) The total amount of the verdict, judgment, or settlement;

(2) The gross amount paid to indemnify the claimant;

(3) Itemized economic and noneconomic damages as allocated by the court; and

(4) Allocated loss adjustment expenses paid by the insuring entities and the insured.

NEW SECTION

WAC 284-24D-310 What information must be reported if the court does not itemize damages or a claim is settled by the parties? When reporting claims under RCW 48.140.030 (10)(b), the reporting entity must report losses on a gross basis, including:

(1) The total amount of the verdict, judgment, or settlement;

(2) The gross amount paid to indemnify the claimant;

(3) Paid and estimated economic damages; and

(4) Allocated loss adjustment expenses paid by the insuring entities and the insured.

NEW SECTION

WAC 284-24D-320 How should "companion claims" be reported? If more than one claim is filed with a reporting entity due to an incident of medical malpractice, the reporting entity must report companion claims in this manner:

(1) If a claimant makes a claim against more than one facility or provider, the reporting entity must assign the same incident identifier to each "companion claim."

(2) The reporting entity must maintain all data required under chapter 48.140 RCW and this chapter for each facility or provider it defends.

(3) Indemnity payments and allocated loss adjustment expenses paid to defend and settle each claim must be reported separately

for each facility or provider. The reporting entity must allocate:

(a) Indemnity payments between defendants based on an assessment of comparative fault; and

(b) ALAE payments between defendants based on which defendant benefited from the defense services.

(4) If the reporting entity makes payments in the absence of clear legal liability, it may allocate claim or ALAE payments equally among all defendants.

(5) Under this section, the reporting entity is responsible for reporting incident level data only for its own claims.

NEW SECTION

WAC 284-24D-330 How much detail is required when reporting allocated loss adjustment expenses? When reporting allocated loss adjustment expenses under RCW 48.140.030 (10)(a)(v) or (b)(iv), the reporting entity must report:

(1) ALAE for defense counsel, including both in-house and outside counsel;

(2) ALAE for expert witnesses, including both in-house and outside experts;

(3) All other ALAE; and

(4) Total ALAE.

NEW SECTION

WAC 284-24D-340 If defense services are provided by company employees, must company overhead be reported with ALAE? (1) Some insuring entities and self-insurers use the services of internal staff to defend claims. For example, an insuring entity or self-insurer may:

(a) Ask its professional medical staff to:

(i) Evaluate medical care;

(ii) Review medical records; or

(iii) Assist in case preparation.

(b) Retain in-house legal counsel to:

(i) Assess risk of litigation;

(ii) Evaluate legal issues;

(iii) Engage in case preparation or management activities, or settlement negotiations.

(2) When calculating ALAE, a reporting entity that uses internal staff to defend a claim as described in subsection (1) of this section and WAC 284-24D-020(1):

(a) Must include salary, benefits and an allocation for

overhead for those employees; and

(b) May use average salaries and time studies when calculating ALAE.

NEW SECTION

WAC 284-24D-350 How are economic damages allocated under RCW 48.140.030 (10)(b)(iii)? If the reporting entity makes indemnity payments to a claimant, the reporting entity must allocate economic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not allocate using a fixed formula, such as fifty percent of total paid indemnity, to economic damages.

NEW SECTION

WAC 284-24D-360 What elements of economic loss must a reporting entity include when reporting economic damages? When reporting paid and estimated economic damages, reporting entities must use reasonable judgment to estimate the following elements of loss:

(1) Medical expenses;
(2) Loss of earnings;
(3) Burial costs;
(4) Cost of obtaining substitute domestic services;
(5) Loss of employment; and
(6) Loss of business or employment opportunities.

NEW SECTION

WAC 284-24D-362 What process must a person use to estimate economic damages? If a reporting entity makes indemnity payments to a claimant that include compensation for future economic damages, the person calculating damages must use the principles listed in this section.

(1) Where appropriate, the person estimating economic damages must:

(a) Project the elements of loss listed in WAC 284-24D-360:

(i) For the duration of the injury or disability; or

(ii) In the event of death, for the anticipated life span of

the injured person; and

(b) Discount damages to present value;

(c) Consider related factors, such as:

(i) Issues of negligence and liability;

(ii) The relative strength of the defense; and

(iii) The component of the claim payment driven by economic damages.

(2) Reporting entities must select reasonable discount factors when estimating economic damages.

NEW SECTION

WAC 284-24D-364 What sources of information can a reporting entity use to estimate economic damages? When estimating economic damages, the person estimating damages may use data from public sources, such as the Bureau of Labor Statistics, to supplement data collected during the claim investigation.

NEW SECTION

WAC 284-24D-366 Will the OIC provide guidelines or tools which reporting entities can use when estimating economic damages? From time to time, the OIC may publish information or suggestions that reporting entities can use when estimating economic damages. Periodically, the OIC will update its internet site to include links to documents or information of interest to reporting entities.

NEW SECTION

WAC 284-24D-370 How are paid and estimated economic damages reported under RCW 48.140.040 (10)(b)(iii)? A reporting entity must:

(1) Combine all elements of paid and estimated economic loss described in WAC 284-24D-360; and

(2) Report one figure for paid and estimated economic loss to the commissioner.

Chapter 284-24E WAC

MEDICAL MALPRACTICE CLAIM SETTLEMENT DATA REPORTING RULES FOR ATTORNEYS AND CLAIMANTS

NEW SECTION

WAC 284-24E-010 Purpose. This chapter contains procedural rules to implement RCW 7.70.140. This chapter describes the rules, practices and procedures that claimants and their attorneys must use to report claim settlement data to the commissioner.

NEW SECTION

WAC 284-24E-020 Definitions. The definitions in this section apply throughout this chapter.

(1) "Claim" means the same as in RCW 48.140.010(1).

(2) "Claimant" means the same as in RCW 48.140.010(2), and, for reporting purposes, includes a claimant's legal representative.

(3) "Commissioner" means the insurance commissioner.

(4) "Facility" means the same as in RCW 48.140.010(6).

(5) "Insuring entity" means the same as in RCW 48.140.010(8).

(6) "Medical malpractice" means the same as in RCW 48.140.010(9).

(7) "OIC" means office of insurance commissioner.

(8) "Provider" means the same as in RCW 48.140.010(7).

(9) "Record identifier" means the number assigned to a claim by the reporting site when a person first enters claim settlement information.

(10) "Reporting site" means the OIC web-based application that attorneys and claimants must use to report medical malpractice claim settlement data.

(11) "Self-insurer" means the same as in RCW 48.140.010(11).

(12) "User ID" is a permanent number assigned by the reporting site to any claimant or attorney who reports claim settlement data.

NEW SECTION

WAC 284-24E-030 How will the commissioner ensure data confidentiality under RCW 48.140.060(2)? RCW 42.56.400(11) protects data filed under RCW 7.70.140 from public disclosure. To ensure data confidentiality, the commissioner will:

(1) Develop a secure web-based data reporting application;

(2) Train OIC staff on applicable laws and agency practices related to protecting confidential and privileged information;

(3) Limit access to the claim data base to OIC staff responsible for preparing the statistical summaries and annual report;

(4) Develop and implement confidentiality procedures to be used by staff that has access to the closed claim data base;

(5) Develop procedures to use if data are accidentally released; and

(6) Use aggregate data in summaries and reports so that individual claim data cannot be identified.

NEW SECTION

WAC 284-24E-040 How is claim settlement data reported to the commissioner? Persons reporting claim settlement data must use the reporting site maintained by the commissioner. To help attorneys and claimants collect data, the commissioner will post a reporting form on the OIC internet site so that claim settlement data can be organized before it is entered into the reporting site.

NEW SECTION

WAC 284-24E-050 How will the OIC assign user ID codes? The reporting site will assign a permanent user ID to an attorney or claimant the first time the attorney or claimant enters claim settlement data into the reporting site.

NEW SECTION

WAC 284-24E-060 What types of settled claims must be reported to the commissioner? If a medical malpractice claim is actionable under chapter 7.70 RCW and the claimant receives an indemnity

payment from an insuring entity, self-insurer, facility or provider, the claimant or his or her attorney must report claim settlement data to the commissioner.

NEW SECTION

WAC 284-24E-063 When is a claim considered settled and subject to reporting with the OIC? A claim is settled when the claimant:

(1) Receives final indemnity payment(s) from all defendants;

(2) Pays all related legal expenses; and

(3) Pays all related attorney fees agreed to by the claimant and his or her attorney.

NEW SECTION

WAC 284-24E-070 Are write-offs or other small sums of money provided as customer service gestures considered claims? If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under RCW 48.140.010(1). Claimants are not required to report these types of accommodations to the commissioner.

NEW SECTION

WAC 284-24E-080 Who has the primary responsibility for reporting claim settlement data to the commissioner? (1) If a claimant is represented by an attorney, the attorney must report claim settlement data to the commissioner after the claim is settled.

(2) If a claimant is not represented by an attorney:

(a) The claimant must report claim settlement data to the commissioner; and

(b) An insuring entity, self-insurer or provider may assist or inform the claimant of his or her reporting responsibilities.

NEW SECTION

WAC 284-24E-090 When are claim reports due? Under RCW 7.70.140, a claimant or his or her attorney must report claims settled in the preceding calendar year to the commissioner.

(1) Beginning in 2009, claim settlement reports for the prior calendar year are due by March 1.

(2) An attorney or claimant may enter data into the reporting site at any time after the claim is settled, but no later than March 1.

NEW SECTION

WAC 284-24E-100 Can settlement reports be reopened to make changes or corrections to previously reported data? The reporting site will allow an attorney or claimant to change previously reported claim settlement data, subject to these rules:

(1) OIC will freeze data contained in the reporting site from March 15 through June 30 each year so the OIC can prepare reports and statistical summaries can be prepared as required by RCW 48.140.040 and 48.140.050. The commissioner may accept changes to previously reported data if a correction or omission will significantly affect the conclusions stated in the annual report.

(2) After June 30, the reporting site will allow an attorney or claimant to change previously reported data.

(a) An attorney or claimant can reopen a claim report using their permanent user ID and the record identifier and make changes or corrections to data.

(b) Changes and corrections submitted after June 30 of each year will appear in future reports and statistical summaries.

NEW SECTION

WAC 284-24E-110 How should claim disposition information be reported? When reporting the final method of claim disposition under RCW 7.70.140 (2)(b)(v), an attorney or claimant must describe the method of claim disposition using one of the descriptions listed below:

(1) Claim is settled by the parties.

(2) Claim is disposed of by a court when the court issues a:

(a) Directed verdict for plaintiff;

(b) Judgment notwithstanding verdict for defendant (judgment for plaintiff);

(c) Judgment for plaintiff; or

(d) Judgment for plaintiff after appeal.

(3) Claim settled by alternative dispute resolution process, whether resolved by:

(a) Arbitration;

(b) Mediation;

(c) Private trial; or

(d) Other type of alternative dispute resolution process.

NEW SECTION

WAC 284-24E-120 How should information about the timing of the settlement be reported? Persons reporting claims must report whether the claim is settled:

(1) Before filing suit, requesting arbitration or mediation hearing;

(2) Before trial, arbitration or mediation;

(3) During trial, arbitration or mediation;

(4) After trial or hearing, but before judgment or award;

(5) After judgment or decision, but before appeal;

(6) During an appeal; or

(7) After an appeal.

NEW SECTION

WAC 284-24E-130 How is the judgment or settlement amount reported? Persons reporting claims must report the total amount paid by all defendants to the claimant to settle the claim.

NEW SECTION

WAC 284-24E-140 How are structured settlements reported? (1) If a claim is settled with a structured settlement agreement, the attorney or claimant must report the lump-sum payment that is paid for the annuity.

(2) If a claim is settled with a combination of a lump-sum payment to the claimant and a structured settlement, the attorney or claimant must report the sum of both payments.

NEW SECTION

WAC 284-24E-150 How should claims settlement data be reported if there is more than one defendant? An attorney or claimant must wait until all claims are settled before reporting under RCW 7.70.140. After all claims are settled, the person reporting claim settlement data must report these data to the commissioner:

(1) The total of all settlements paid by all defendants; and

(2) The total amounts paid by the claimant for legal expenses, itemized by:

(a) Court costs;

(b) Expert witnesses fees; and

(c) Attorney fees and expenses.